(Sample #1)

## Emergency Action Plan Diabetes Healthcare

Student's Name		Grade	
Address	Home Phone		
Father/Guardian			
Phone: Home	Work	Cell	
Mother/Guardian			
Phone: Home	Work	Cell	
Other person to contact in an En	_ •		
Address			
Phone: Home	Work	Cell	
Hospital Preferred			
_			
Phone			
	cy items to be left at scho	ool:	
_	Glucagon _		
	Blood gluc		
		Insulin	
	Syringes		
	Other		
	te, such as ½ carton of mil	utinely followed at school is: to give lk, ½ cup fruit juice, or ½ cup non diet conscious, call 911.	
I approve the above emergency he	althcare action plan as wri	itten Yes No	
Please make the following changes	s to the emergency health	care action plan:	
	<del></del>		
	- (continued on back)	) <b>-</b>	

## (Sample #1 Continued)

## Emergency Action Plan Diabetes Healthcare

List other additional infor	mation or significant special health concerns or	f this student.
equipment I have provide	rgency blood glucose testing by the school nursed. I understand that when the school nurse or colood glucose testing, the parent/guardian will be No	designee is not
Additional directions rega	arding blood glucose testing:	
Written and submitted by	: Nurse or Designee	Date
Reviewed and signed:	Ç .	
Reviewed and signed.	Parent/guardian	Date
	Student	Date
	Physican or Health Care Provider	Date
To be reviewed		
	Date	
The emergency healthcare	e action plan should be revised according to the	child's specific

The emergency healthcare action plan should be revised according to the child's specific needs, at least annually.

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses. Sample of Springfield School District Emergency Action Plan – Diabetes Healthcare.